Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE OPEN ENROLLMENT 2008-2009

AGENCY CODE	AGENCY	DATE RECEIVED

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	☐ MALE ☐ FEMALE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )

Are you enrolling a Domestic Partner?(circle one)	**Yes or No**
Is your Domestic Partner: (circle one)	**Pre-Tax or Post-Tax**
Are you enrolling an Older Child(ren) that is neither a full-time student nor a disabled dependent?(circle one)	**Yes or No**
Is your Older Child(ren): (circle one)	**Pre-Tax or Post-Tax**

To qualify a Domestic Partner, you will need to complete and submit the *DOMESTIC PARTNER AFFIDAVIT FORM* (this form must be notarized) and the *DECLARATION OF TAX STATUS FORM* and submit with your enrollment. To qualify as an Older Child (ages 19 to 25 and neither a full-time student nor a disabled dependent), the Older Child must have been covered on an ADOA plan at the age of 18 years old (see the Open Enrollment Guide for qualifications of an Older Child). You will need to complete and submit the *DECLARATION OF TAX STATUS FORM* and submit with your enrollment. These forms can be found on the benefit options website *www.benefitoptions.az.gov*. It is your responsibility, as the employee, to determine whether a dependent is considered a PRE-TAX OR POST-TAX dependent for purposes of determining whether imputed income will apply. Please consult a tax advisor before you certify that your Domestic Partner or Older Child is a PRE-TAX OR POST-TAX dependent. Notice of any change in dependent tax status must be communicated to ADOA within 31 days of the change.

MEDICAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE MEDICAL COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
Counties: Gila, Maricopa, Pima, Pinal, Santa Cruz						
RAN+AMN (HMA) EPO		☐ $30.00		☐ $60.00		☐ $150.00
UnitedHealthcare (UHC) EPO		☐ $30.00		☐ $60.00		☐ $150.00
Arizona Foundation (AZF) PPO		☐ $145.00		☐ $290.00		☐ $415.00
UnitedHealthcare (UHC) PPO		☐ $145.00		☐ $290.00		☐ $415.00
All Other Counties						
RAN+AMN (HMA) EPO		☐ $30.00		☐ $60.00		☐ $150.00
Arizona Foundation (AZF) PPO		☐ $145.00		☐ $290.00		☐ $415.00
OUT-OF-STATE						
Beech Street PPO		☐ $30.00		☐ $60.00		☐ $150.00

DENTAL PLANS (Employee Monthly Cost Listed)

☐ **I DECLINE DENTAL COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 2	CODE	Tier 3
TOTAL DENTAL ADMINISTRATORS		☐ $5.00		☐ $9.00		☐ $14.00
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE		☐ $16.00		☐ $37.00		☐ $63.00

VISION PLAN (Employee Monthly Cost Listed)

☐ **I DECLINE VISION COVERAGE**

SELECT A PLAN	CODE	Tier 1	CODE	Tier 3
AVESIS VISION COVERAGE		☐ $6.34		☐ $17.18

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OPEN ENROLLMENT 2008-2009

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STATE OF ARIZONA ACTIVE OPEN ENROLLMENT 2008-2009 CONTINUED

DEPENDENTS - List all eligible dependents to be enrolled or disenrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS)	DATE OF BIRTH (MM/DD/YY)	POST-TAX DEPENDENT	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT	DISABLED	ADD OR DELETE	INDICATE PLAN TYPE MEDICALl(M) DENTAL(D) VISION(V)
LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE	**REQUIRED**	**Y OR N**			**Y OR N**	**Y OR N**	**A OR D**	
Employee			S- Spouse C- Child D- Domestic Partner G- Guardian P- Placed for adoption T- Stepchild					
Spouse or Domestic Partner			☐ S ☐ D	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V
			☐ C ☐ G ☐ P ☐ T	☐M ☐F				☐ M ☐ D ☐ V

SHORT-TERM DISABILITY

The Standard Insurance Company provides the Short-Term Disability coverage. If you elect coverage, you will pay $0.87 for every $100 of your base salary per month. Please see the Open Enrollment Guide for more information regarding Short-Term Disability coverage.

☐ **I DECLINE STANDARD SHORT-TERM DISABILITY** ☐ **I ELECT STANDARD SHORT-TERM DISABILITY**

SUPPLEMENTAL LIFE INSURANCE

Supplemental coverage is available in increments of $5,000. Your cost for Supplemental Life and AD&D insurance is based on your age as of October 1st (the first day of the plan year). Premiums for Supplemental Life coverage above $35,000 are paid on an after-tax basis. You may elect to increase or decrease your Supplemental Life coverage during Open Enrollment. The maximum amount you may elect during Open Enrollment is $20,000. Each year you may increase, in multiples of $5,000, by up to a maximum $20,000. You can decrease in multiples of $5,000 or cancel coverage during Open Enrollment each year. The maximum amount of Supplement Life insurance that you can elect through the State's group plan is three times your annual base salary or $300,000, whichever is less.

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE**	☐ **INCREASE BY $5,000**	☐ **INCREASE BY $15,000**
☐ **NO CHANGE** ☐ **DECREASE BY $_________**	☐ **INCREASE BY $10,000**	☐ **INCREASE BY $20,000**

DEPENDENT LIFE INSURANCE

☐ **$2,000**	**$0.94/MONTH**	**Plan Code 02**	☐ **$12,000**	**$5.64/MONTH**	**Plan Code 12**
☐ **$4,000**	**$1.88/MONTH**	**Plan Code 04**	☐ **$15,000**	**$7.06/MONTH**	**Plan Code 15**
☐ **$6,000**	**$2.82/MONTH**	**Plan Code 06**	☐ **I DECLINE DEPENDENT LIFE INSURANCE**		

PRIMARY BENEFICIARY (List additional or Trust information on a separate form which you may obtain from your benefits liaison)

Beneficiary Last Name, First Name	Date of Birth
Beneficiary Street, City, State, Zip Code	Phone No.

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/domestic partner and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In addition, I have read and understand the declarations.

SIGNATURE:____ DATE:______________

Return form to: ADOA Benefit Services Division, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 OR FAX TO:602-542-4744

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